Procedure D0230 - Intraoral - Periapical Each Additional Film
Limit: A total of fourteen (14) X-rays per patient, per 12 12 month period, per provider

Procedure D0330 - Panoramic - Maxilla and Mandible Film
Limit: One (1) per patient, per every twenty-four (24) month period, per provider

PREVENTIVE SERVICES (Available to all ages)

Procedure D1110 - Prophylaxis - Adult (Excludes Fluoride)
Note: Adult is defined as age 17 and over

Procedure D1201 - Topical Application of Fluoride (Including Prophylaxis) Children
Note: Child is defined as 16 and under

Procedure D1202 - Topical Application of Fluoride (Including Prophylaxis)
Note: Includes recipients age 17-20

Limit: One (1) per 12 month period, per patient

ORAL SURGERY (Available to all ages)

Procedure D7110 - Extraction, Single Tooth
Limit: One per tooth, per patient

Procedure D7120 - Extraction, Each Additional Tooth
Limit: One per tooth, per patient

Procedure D7130 - Root Removal - Exposed Roots
Note: Root removal is not payable on same date of service to same tooth as the tooth's extraction.

IMPACTIONS

Procedure D7210 - Surgical removal of erupted tooth, requires elevation
Procedure D7211 - Surgical removal of erupted teeth, each additional

IMPACTIONS (Continued)

Procedure D7220 - Impaction that requires incision of overlying soft tissue and removal of tooth
Procedure D7221 - Surgical removal, soft tissue impaction, each additional
Procedure D7230 - Impaction that requires incision of overlying soft tissue, elevation of a flap, and either removal of bone and tooth or sectioning and removal of tooth
Procedure D7231 - Surgical removal, partial bony impaction, each additional
Procedure D7240 - Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of the tooth for removal
Procedure D7241 - Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances
Procedure D7242 - Surgical removal, complete bony impaction, single each
Procedure D7243 - Surgical removal, complete bony impaction each additional
Procedure D7250 - Root recovery (Surgical removal of residual root)
Procedure D7260 - Oroantral fistula closure (and/or antral root recovery)

NOTE: Extractions performed by general dentists in the outpatient department of the hospital are not reimbursable by the KMAP except in cases determined to be medically necessary and appropriate oral surgical care is unavailable. Documentation will be required prior to any payment consideration. It would be necessary for the dentist to attach a letter of explanation to the claim form. This letter would need to include the diagnosis necessitating hospital care and also a statement that an oral surgeon was not available in the medical service area. This letter must be signed by the dentist; delegated signatures are not acceptable. When appropriate oral surgical care is available, recipients should be referred to a participating oral surgeon who can perform this service in his office.

When the patient has already been admitted to the outpatient department for other dental services, i.e., fillings, root canals, etc., in addition to the extractions, the provider can be reimbursed for the extractions. However, a letter signed by the dentist must be attached to the claim explaining the circumstances of the admission. Pedodontists are excluded from the requirements concerning outpatient department extractions. This policy is monitored through post-payment review.

ENDODONTIC SERVICES (Limited to recipients under age 21)

Procedure D3110 - Pulp Cap - Direct (Excluding Final Restoration)
NOTE: Direct pulp cap is defined as the application of a pulp capping material such as calcium hydroxide is placed directly on or in contact with the vital pulp tissue. Placement of the material over an area in close proximity of the cap but not actually in contact with the pulp chamber does not constitute a direct pulp cap.

Procedure D3220 - Vital Pulpotomy (Excludes Final Restoration)

Procedure D3310 - Root Canal Therapy, Anterior (Excludes Final Restoration)

Procedure D3320 - Root Canal Therapy, Premolar (Excludes Final Restoration)

Procedure D3330 - Root Canal Therapy, Molar (Excludes Final Restoration)

NOTE: The Sargenti method of root canal treatment is not covered under the present root canal procedure codes. When billing for root canal therapy, the procedure constitutes treatment of the entire tooth. It is not appropriate to perform a root canal on only one root of a molar and bill the KMAP for root canal therapy on a molar since that code represents treatment to the entire tooth. These are monitored through post-payment review.

OPERATIVE SERVICES (Available to all ages)

AMALGAM - PRIMARY

Procedure D2110 - Amalgam - One Surface
Procedure D2120 - Amalgam - Two Surfaces
Procedure D2130 - Amalgam - Three Surfaces
Procedure D2131 - Amalgam - Four Surfaces

AMALGAM - PERMANENT

Procedure D2140 - Amalgam - One Surface
Procedure D2150 - Amalgam - Two Surfaces
Procedure D2160 - Amalgam - Three Surfaces
Procedure D2161 - Amalgam - Four or More Surfaces

COMPOSITE RESIN

Procedure D2210 - Silicate Cement per Restoration
Procedure D2310 - Acrylic or Plastic or Composite Resin
Procedure D2330 - Composite Resin - One Surface
Procedure D2331 - Composite Resin - Two Surfaces
Procedure D2332 - Composite Resin - Three Surfaces
Procedure D2335 - Acrylic or Plastic or Composite Resin (Involving Incisal Angle or Four or More Surfaces)
NOTE: This procedure code can not be billed in conjunction with any other operative service code or the procedure code for crowns performed on the same tooth on the same date of service. The use of mastiques is not allowed for this procedure code. Policy is monitored through post-payment review.

Limit: Acrylic, Plastic or Composite Resin Fillings (procedure codes D2310-D2335) are limited to anterior teeth only. Anterior teeth are defined as tooth numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R.

NOTE: The KMAP recognizes five (5) surfaces of a tooth (buccal or labial, mesial, distal, lingual, occlussal or incisal). Any combination of the above procedure codes can be used for a total of 5 surfaces, per tooth, per provider, per date of service. This is monitored by both computer audits and post-payment review.

CROWN (Limited to recipients under age 21)

Procedure D2930 - Prefabricated Stainless Steel Crown - Primary Tooth

Procedure D2931 - Prefabricated Stainless Steel Crown - Permanent Tooth

Procedure D2932 - Prefabricated Resin Crown -
Limit: Anterior Teeth Only

NOTE: Should a provider choose to provide crowns for anterior teeth and/or permanent teeth, the usual and customary charge for a stainless crown must be billed. Since reimbursement for the tooth's restoration is included in the payment for the crown, this procedure cannot be billed in conjunction with any other operative service code for the same tooth number. This policy is reviewed by both system audits and post-payment review.

PROSTHETIC SERVICES (Limited to recipients under age 21)

Procedure W0716 - Transitional appliance, includes one tooth on appliance, upper appliance
Limit: One per 12 month period, per patient

Procedure W0718 - Transitional appliance, includes one tooth on appliance, lower appliance
Limit: One per 12 month period, per patient

Procedure W0725 - Repair of fracture of transitional appliance and space maintainer
Limit: Three per 12 month period, per patient

Procedure W0726 - Repair of fracture and replacement of one broken tooth on a transitional appliance and space maintainer
Limit: Three per 12 month period, per patient

Procedure D5610 - Repair broken complete or partial denture - No teeth damage
Limit: Three per 12 month period, per patient

Procedure D5620 - Repair broken complete or partial denture - Replace one broken tooth
Limit: Three per 12 month period, per patient

Procedure D5640 - Replace broken tooth on denture. No other repairs.

Procedure D5630 - Replace additional teeth - each tooth

Procedure D5750 - Relining upper or lower complete denture (laboratory)
Limit: One per 12 month period, per denture, per patient

Note: The repair of the clasp on removable partial dentures, and relining of removable partial dentures are not presently covered benefits.

ORTHODONTIC SERVICES (Limited to recipients under age 21)

Limit: To any combination of the below procedures per 12 month period totaling two, per patient

Procedure D1510 - Space maintainer, fixed unilateral type

Procedure D1515 - Space maintainer, fixed bilateral type

Procedure D1520 - Space maintainer, removable unilateral type

Procedure D1525 - Space maintainer, removable bilateral type

Procedure D8110 - Removable Appliance Therapy

Procedure D8120 - Fixed or cemented appliance therapy

NOTE: Tooth numbers are no longer required for orthodontic services. See Appendix XVI - Definitions of Dental Procedures

OTHER SERVICES

Procedure D9110 - Palliative (emergency) treatment of dental pain, minor procedures
Limit: One per date of service, per recipient, per dentist

NOTE: Emergency Treatment refers to an actual dental treatment, necessary in an emergency situation, that is not covered by any other procedure on the Dental Benefit Schedule. Only one emergency may exist during any one visit, even though treatment may involve more than one procedure or tooth. It is necessary that both the diagnosis and the actual treatment rendered be entered on each claim form submitted for procedure D9110.

When the emergency treatment is a covered procedure, or a non-emergency, non-covered treatment, the emergency treatment procedure may not be billed. The following list represents unacceptable and therefore non-payable services for procedure D9110.

1. Routine office calls
2. Oral exams
3. Referrals to other dentists or physicians
4. Pins for retention of fillings
5. Saline irrigations
6. Full mouth deep scaling and currettage unless to relieve acute periodental pain

7. Wires revised
8. Dressing changes unless for dry socket
9. Panorex interpretation
10. When D5750 is done on same day as a denture related D9110
11. When D7110 or D7120 are done on same day to same tooth
12. Gingevectomy
13. Appliance removal or removal of braces
14. Frenunectomy
15. Bone Trim with extractions
16. Adjust appliance or retainer
17. Papilloma removal
18. Sutures with extractions
19. Suture removal
20. When D2110 through D2332 are done on same day to same tooth
21. Dispensing drugs
22. Telephone contacts

SECTION IV - SERVICES COVERED

DENTAL BENEFIT SCHEDULE FOR ORAL SURGEONS (Available to All Ages)

The following list contains all procedures payable to oral surgeons under the KMAP Dental Services Program. All other oral surgical procedures, including x-rays, are refererenced in the CPT-4 coding book.

Limit: One extraction per tooth, per patient.

SIMPLE EXTRACTIONS
Procedure D7110 - Extraction, Single Tooth
Procedure D7120 - Extraction, Each Additional Tooth
Procedure D7130 - Root Removal - Exposed Root
NOTE: Root removal is not payable on the same date of service to the same tooth as the tooth's extraction.

IMPACTIONS
Procedure D7210 - Surgical removal of erupted tooth, requires elevation
Procedure D7211 - Surgical removal of erupted teeth, each additional
Procedure D7220 - Impaction that requires incision of overlying soft tissue and removal of tooth
Procedure D7221 - Surgical removal, soft tissue impaction, each additional
Procedure D7230 - Impaction that requires incision of overlying soft tissue, elevation of a flap, and either removal of bone and tooth or sectioning and removal of tooth
Procedure D7231 - Surgical removal, partial bony impaction, each additional
Procedure D7240 - Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of the tooth for removal
Procedure D7241 - Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances
Procedure D7242 - Surgical removal, complete bony impaction, single each
Procedure D7243 - Surgical removal, complete bony impaction each additional
Procedure D7250 - Root recovery (Surgical removal of residual root)
Procedure D7260 - Oroantral fistula closure (and/or antral root recovery)

Questions regarding oral surgical procedures should be directed to the Division of Policy and Provider Services at (502) 564-6890.

G. Family Planning

1. Initial Visit

a. Complete Medical History--A complete medical history shall be obtained and recorded and shall include, but not be limited to:

1) Complete obstetrical history, with menarche and menstrual history, last menstrual period, gravidity, parity, pregnancy outcomes, and complications of any pregnancy and/or delivery.

2) Any significant illnesses, hospitalizations, and previous medical care and the indicated systems review, e.g., cardiovascular, renal, neurologic, hepatic, endocrine, hematologic, gynecologic (Dysmenorrhea, metrorrhagia, menorrhagia, post-coital bleeding, vaginal discharge, dyspareunia) and venereal disease.

3) Previous contraceptive devices or techniques used, and problems related to their use.

4) Present and past physical conditions which might influence choice of contraceptive method, to include:

a) Thromboembolic disease
b) Hepato-renal disease
c) Breast and/or genital problems
d) Diabetic and pre-diabetic conditions
e) Cephalgia and migraine
f) Hematologic phenomena
g) Pelvic inflammatory disease

5) Relevant family health history, including significant recurrent chronic illness, genetic aberrations, and unusual health factors among family members.

6) Relevant psychiatric history, including previous history of mental depression.

7) Social history.

b. Physical Examination--The initial examination shall include:

1) Thyroid palpation

2) Inspection and palpation of breasts and axillary glands, with instructions to the patient for self-examination

3) Auscultation of heart

4) Auscultation of lungs if respiratory symptoms present

5) Blood pressure

6) Weight and height

7) Abdominal examination

8) Pelvic examination, including speculum, bimanual, and rectovaginal examinations

9) Extremities

10) Others as indicated

c. LABORATORY AND CLINICAL TESTS--The recipient shall receive at least the following laboratory and clinical tests.

1) Hematocrit or hemoglobin

2) Urinalysis for sugar and protein

3) Papanicolaou smears

4) Culture for N gonorrhea

5) Serology for syphilis*

d. INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS--The recipient shall be given comprehensive, detailed information concerning reversible and irreversible contraceptive methods available. This information shall include mode of action, advantages and disadvantages, effectiveness, and common side effects of each method. Basic information concerning venereal disease shall also be given.

At the outset of the discussion, the recipient's level of knowledge regarding reproductive functions shall be established and basic information presented where necessary.

Ample time shall be given for the recipient to ask pertinent questions and to relate the presented information to his/her personal situation.

*ONLY WHEN MEDICALLY INDICATED

e. PRESCRIPTION OF CONTRACEPTIVE METHOD--The physician shall prescribe the contraceptive method, based on the medical and psychiatric history, the medical examination, laboratory tests, and the recipient's wishes. The physician or the registered nurse shall give complete verbal instructions as to use of the method, and the recipient shall also be given complete written instructions.

ARNP limitations will be based on the written protocols as they relate to the specific contraceptive method.

ALL OF THE PRECEDING SERVICES MUST BE COMPLETED AND DOCUMENTED BEFORE BILLING FOR AN INITIAL EXAMINATION. Each client is limited to one initial visit per provider per lifetime.

2. Revisits by Contraceptive Patients

Subsequent visits to the clinic shall be scheduled at least annually and in accordance with the contraceptive method prescribed.

a. ORAL CONTRACEPTIVE RECIPIENTS shall return to the clinic not later than three months after the initial prescription is issued, and thereafter as indicated, or at least annually.

During the first scheduled follow-up visit, at least the following services shall be provided:

1) An interim history, to include pain (especially in the arms and chest), headaches and visual problems, mood changes, leg complaints, vaginal bleeding and/or discharge, and VD history
2) Review of menstrual history
3) Blood pressure, weight check
4) Laboratory tests as indicated

b. I.U.D. RECIPIENTS shall return to the clinic not later than three months following insertion of the device, at which time the following services shall be provided:

1) A repeat pelvic examination with visual inspection of the cervix
2) Blood pressure and weight
3) Menstrual history review
4) Review of abdominal symptoms, fever, vaginal bleeding/ discharge
5) Laboratory tests as indicated

c. DIAPHRAGM RECIPIENTS shall be seen within two to four weeks after initial fitting, to assure that the recipient can insert, position, and remove the diaphragm correctly.

d. RHYTHM METHOD--Recipients using the rhythm method shall be seen in one month after initial visit, for instruction and assessing complaints, and six months thereafter, for review of menstrual calendar and temperature charts.

e. OTHER--Recipients using other methods of contraception do not require a routine follow-up visit for medical review or examination prior to the required annual visit.

3. Annual Visits

Annual visits are required for all contraceptive recipients. During these visits, at least the following services shall be provided:

a. Interim health history to update all medical and psychiatric information required in the initial history.
b. Complete physical examination, by the physician or ARNP, including all procedures required during the initial physical exam.

c. Repeat of initial laboratory and clinical procedures detailed in Section 1.c., page 3.
d. Evaluation of use of current method of contraceptive and change in prescription when indicated. Any change shall be based on interim medical and psychiatric history, physical examination and laboratory tests, and the recipient's satisfaction and success with the current method.
e. Complete verbal and written instructions if prescription is changed.

Annual visits are limited to one per nine months.

6. Sterilization Counseling

Counseling services involving transmittal of complete information regarding male and/or female sterilization procedures shall be provided the individual or couple requesting such services, plus full information concerning alternate methods of contraception. These counseling services shall be provided by the physician, the advanced registered nurse practitioner and shall meet at least the following conditions:

a. The recipient's level of knowledge regarding reproductive functions shall be assessed, and proper instruction given where needed.
b. A full discussion of reversible contraceptive methods shall be given.
c. The recipient shall be made fully aware that the sterilization procedure will most likely be irreversible.
d. Sterilization procedures shall be explained in detail, with use of charts or body models.
e. The recipient shall be given complete information concerning possible complications and failures.
f. The relative merits of male versus female sterilization shall be discussed with both partners, if both are available.
g. The recipient shall be given information relating to the fact that sterilization does not interfere with sexual function or pleasure.
h. The function of the counselor is to provide information, and he/she shall in no way seek to influence the recipient to be sterilized.

The following conditions shall be considered contraindications for voluntary sterilization:

a. The recipient has physical, mental, or emotional conditions which could be improved by other treatment.
b. The recipient is suffering from temporary economic difficulties which may improve.
c. The recipient or couple feel that they are not yet ready to assume the responsibilities of parenthood.
d. The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

If sterilization is not desired, alternate methods of contraception shall be discussed.

See Section IV, pages 4.5 and 4.6 for requirements related to sterilization procedures.

7. Infertility Services

Provision shall be made for screening and diagnosis of fertility problems. Recipients requesting infertility services shall receive complete physical exam and history, shall be given full information concerning reproductive functions, available tests and possible remedial procedures, and shall be referred to and accepted by a medical provider who can make available at least the following services:

a. Complete history and physical examinations of both partners.
b. G.C. and serologic testing of both partners.
c. Basal body temperature monitoring.
d. Semen analysis.
e. Cervical mucus examination.
f. Vaginal smear for assessment of estrogen production.
g. Endometrial biopsy.
h. Hysterosalpingogram.

8. Vaginal Infections

   The clinic shall be responsible for diagnosis and treatment or referral of recipients suffering from vaginal infections.

9. Emergency Services

   Provision shall be made for handling emergencies related to contraceptive services when the clinic is not in session.

10. Pregnancy Testing

    The clinic shall provide pregnancy testing on request by the recipient, when indicated by the history or physical examination, or when the prescribed method of contraception would indicate need for same.

11. Referrals

    The clinic shall be responsible for referral to the proper resource in the following circumstances, and for ensuring that the recipient is accepted by the resource to which he/she is referred.

    a. Medical problems indicated by history, physical examination, or laboratory or clinical test.
    b. For pregnancy related services when appropriate.
    c. For social case work not appropriately handled by agency personnel.
    d. For abortion counseling.

12. Supplies

The family planning agency shall make available to the recipient, on a continuing basis where applicable, at least the following contraceptive supplies:

a. Oral contraceptives
b. Intrauterine devices
c. Diaphragms
d. Foams
e. Thermometers for rhythm method
f. Jellies and Creams
g. Condoms

13. Medical Records

The family planning agency shall maintain complete recipient medical records, which shall contain but not be limited to the following:

a. Initial and interim histories -- medical, psychiatric, and social.

b. Record of initial and interim physical examinations.

c. All laboratory reports.

d. Description of each visit, to include services provided, supplies dispensed, and progress notes (recipient response to service or to contraceptive method).

e. Record of all referrals made, to include reason for referral, source to whom recipient was referred, and any information obtained as a result of referral.

f. Record of any follow-up by outreach or other agency staff outside clinic setting.

14. Availability of Services

Services of the family planning agency shall be available to each and every person requesting same, regardless of sex, race, age, income, number of children, marital status, citizenship or motive.

HCPCS Local Family Planning Services
Procedure/Supply Codes

Type of Contraceptive Dispensed - This Visit	Physician/Advanced Registered Nurse Practioner					Registered Nurse		LPN
	Intake or Initial Visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Supply and Counseling Visit	Annual Revisit and Examination	Supply and Counseling Visit	Supply Only	Supply and Counseling Visit
Birth Control Pills	X1110	X1210	X1310	X1410	X1510	X2410		
Intrauterine Device	X1120	X1220	X1320	X1420	X1520	--	--	--
Diaphram	X1130	X1230	X1330	X1430	X1530	--	--	--
Foam/Condoms	X1140	X1240	X1340	X1440	X1540	X2440	X0024	X3440
Rhythm	X1150	X1250	X1350	X1450	X1550	X2450	X0025	X3450
Injection	X1170	X1270	X1370	X1470	X1570	--	--	--
Referral for Sterilization	X1180	X1280	X1380	X1480	X1580	X2480	--	--
Other(Specify)	X1190	X1290	X1390	X1490	X1590	X2490	X0029	X3490
None Dispensed This Visit	X1100	X1200	X1300	X1400	X1500	X2400	--	X3400

SECTION IV - SERVICES COVERED

H. Pharmacy

Pharmacy services must meet the standards of the pharmacy component of the KMAP. A pharmacy component of the Primary Care Center must hold an operation permit from the Board of Pharmacy in the state in which the Center is located.

1. Providers must maintain such records as are necessary to fully disclose the extent of the service provided, including the original prescription and its refills. The original prescription must be maintained in a numerical order prescription file. If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made. Records must be maintained as a prescription file independent of recipients' case records for a period of not less than five (5) years from date of service. Providers must furnish to the Department or its authorized representatives, as requested, information regarding any claims for pharmacy services rendered under the Medical Assistance Program.

2. Notification must be made to the KMAP regarding any change in the status of the pharmacy component.

3. The cost of covered drug items which are prescribed and certified to be required for eligible Program recipients by a duly-licensed physician, dentist, osteopath, podiatrist, or optometrist will be allowed under conditions established in the Primary Care Principles of Reimbursement. "Duly-licensed physician, dentist, osteopath, podiatrist, or optometrist" would refer to those individuals so licensed under the existing state regulations and statutes effective in the state wherein they practice.

4. In addition to standard drug pre-authorization, there are certain drugs which may be considered generally suitable for individuals in specific living circumstances and/or with a characteristic pattern of health needs (e.g. personal care home recipients). In these circumstances, groups of drugs may be pre-authorized for individuals upon appropriate request, with no individual pre-authorization numbers assigned for the drugs.

The drugs which under these circumstances may be approved as a group, will be outlined in a separate section of the Quarterly Outpatient Drug List.

5. The Pharmacy Program uses several investigative and screening methods to detect any abuse on the part of the prescriber, pharmacy, or recipient. Computer print-outs are reviewed periodically (e.g., quarterly). Data is compared against norms of the specific medical service areas for number of prescriptions per recipient, cost per prescription, and cost per recipient. If the figures show significant deviations from the norms, the pharmacy is flagged for in-depth review. Records are more thoroughly examined and physician, pharmacy and recipient contacts are initiated to determine the cause for the unusual pattern of care. If inappropriate practices are found to be provider oriented, the case(s) is (are) referred to the respective Peer Review Committee for recommendations for Program action, which could include non-payment and/or suspension from the Program.

6. The Kentucky Medical Assistance Program Outpatient Drug List

   The KMAP Outpatient Drug List indicates the specific drugs which are covered by the Program. Limitation in available funds has necessitated the development of the Drug List. The Drug List is evaluated and revised in accordance with recommendations from prescribers and pharmacists who participate in the Program, in accordance with funds available, and in accordance with the interests and needs of Program recipients. Information obtained from consultation with the Formulary Subcommittee (an advisory committee appointed by the chairman of the Advisory Council for Medical Assistance), and with practitioner/staff associated with medical schools in the State is also utilized in accomplishing revisions to the Drug List.

7. Prescription Quantities

It is expected that prescribers will prescribe the quantities which most nearly fulfill the recipient's needs with due regard for economy and prevention of wastage. Quantities of medication dispensed must be the same as prescribed by the physician. The KMAP will not reimburse those prescriptions when quantities prescribed have been changed by the pharmacy without approval by the physician. This policy will be monitored through post payment review.

Prescriptions should be filled for the EXACT quantity ordered by the prescriber. If a change in quantity is made, the PRESCRIBER must approve of the change and properly document it in the patient's record and include the following information:

a. the authorized changed quantity amount
b. the reason for the change
c. certification that the pharmacist contacted the prescriber and requested the change which the prescriber then authorized
d. the name of the pharmacist requesting the change
e. the date of authorization for quantity change

Also, the PHARMACIST must properly document the change in quantity either on the Rx itself or on an attached document and include the following information:

a. the authorized changed quantity amount
b. the reason for the change
c. certification that the prescriber has been contacted and concurred with the change
d. the name of the prescriber and name of any office worker who transmitted authorization on behalf of the prescriber
e. date of authorization for quantity change
f. name of pharmacist receiving authorization and filling the prescription
g. prescription number involving quantity change

Program coverage will not be allowed for duplicate prescriptions - i.e. more than one prescription for a drug listed under the same reference number (generic category) and dispensed to the same recipient by the same pharmacy on the same day.

8. Prescriptions: New and Refills of Originals

Prescribers must properly document (either in the patient's chart or in the Refill Log as the case may be) all Rx's prescribed by them for Medicaid patients and include the following information:

a. drug name
b. strength and dosage of drug
c. quantity
d. refill limits
e. days supply
f. instructions for taking medicine

Prescriptions covered under the KMAP Outpatient Drug List and through the Pre-Authorization Program cannot be refilled more than five (5) times or more than six (6) months (180 days) from the date of the original prescription. Once a prescription has reached this stage, a new prescription must be authorized and signed by the prescriber in accordance with provisions in #13. Prescription Authorization and a new prescription number must be assigned.

When listing refills on the billing statement, the original prescription number should be entered. Only the date of service would differ from the information pertaining to the original prescription.

Prescriptions bearing refill instructions should be refilled at appropriate intervals as shown by the dosage schedule on the prescription for the specific drug.

PRESCRIPTION REFILL NOTATIONS - State regulations require that the pharmacist record refills of all prescription-legend drugs by writing the date of the refill together with his/her name or initials on the back of the original prescription. The date of the refill may be stamped on the prescription if the pharmacist so desires.

In instances where the KMAP has been billed for prescription refills for which no documentation exists in the dispensing pharmacy's records the charge will be disallowed or a refund must be made by the dispensing pharmacy to the Kentucky State Treasurer in the amount of Program payment for unauthorized refills.

If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made.

9. Legal Requirements

Current Federal and State regulations will pertain in all instances where the KMAP requirements do not specify a more stringent policy.

10. Product Standards

Standards for quality, safety, and effectiveness of drugs for which the KMAP makes payment shall be those set forth in the "United States Pharmacopeia" or "National Formulary," where applicable, in any directives issued by the Food and Drug Administration, where applicable, and in any state or federal regulations, where applicable.

11. Prescription Substitution

Except as provided by Kentucky's Drug Product Selection ("Generic Drug") Law, specified or express permission, approval, or consent of the prescriber is required before a pharmacist may substitute any other drug, medicine, chemical, or pharmaceutical preparation.

If such approval or consent is obtained from the prescriber, the brand name or the name of the manufacturer of the drug, medicine, chemical, or pharmaceutical preparation dispensed must be written on the prescription by the pharmacist.

12. Prescription Authorization

A supervising physician must sign all prescriptions prescribed by an intern working under his/her direct supervision in a medical teaching institution.

Practitioner authorization, i.e. actual signature of the prescriber shall be required on all prescriptions not phoned in, on all Schedule II controlled substance prescriptions, and when the physician override (certification of brand name necessity) procedure is being used. For telephone prescriptions (but not including the preceding) the pharmacist shall enter on the prescription form the name of the prescriber and the initials of the pharmacist. Since the date and signature of the pharmacist must appear on all oral prescriptions for Schedule III, IV, and V controlled substances, additional initialing by the pharmacist is not required.

13. Outpatient Drug List

The Outpatient Drug List is provided as a publication separate from this manual. Changes to this list are mailed on a monthly basis.

14. Additions To Outpatient Drug List

Drug products conforming EXACTLY in active ingredient content to the respective generic name on the Drug List can be added to the KMAP Outpatient Drug List when requested by prescribers and pharmacists who participate DIRECTLY (i.e. either prescribe drugs for or dispense prescriptions to KMAP recipients) in the KMAP, if the following conditions are met:

a. The name, address, telephone number, prescriber license number or KMAP primary care number, of the individual initiating the request must be provided.

b. The requested drug product must have an "effective" or "probably effective" FDA rating.

c. A copy of the notification of New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) approval from the Bureau of Drugs and/or Office of New Drug Evaluation, National Center for Drugs and Biologics, Food and Drug Administration (FDA), Rockville, Maryland, must be provided, or the requested drug product must be included as an approved drug in the current edition of the FDA publication, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations." (Note: This requirement will not apply to products marketed originally prior to 1938.)

d. COMPLETE information regarding the requested drug product must be provided and certified to the KMAP. This includes: generic name, product name, manufacturer name, distributor name (if different), National Drug Code Number, package size, cost to pharmacy of most frequently purchased packaged size, strength and dosage form, listing of all active ingredients together with respective strength of each ingredient. (Note: Forms for the submission of this required information are available from the KMAP, upon request.)

   Also, if a requested product falls within a multiple source group which includes products deemed to be therapeutically equivalent by the Food and Drug Administration (FDA) and so designated by an "A" code in the FDA publication referenced in c. above, the requested product also must have an "A" code in order to be added to the KMAP Outpatient Drug List.

e. The requested drug product must conform exactly in active ingredient content to the respective generic entity.

15. Drug Pre-Authorization

The Pharmacy Program includes a drug pre-authorization procedure which supplements the KMAP Outpatient Drug List. Some medications, which are not on the Drug List and which are essential for a recipient to avoid hospitalization or higher levels of care, may be made available through this procedure. Physician consultants and agency employed nurses review each request and make determinations on the basis of Program criteria.

Certain criteria must be met before the drug is approved. (See Appendix.) If the requested drug is approved, the recipient's choice of pharmacy is contacted to determine whether the pharmacy will provide the approved drug.

The original authorization is valid for a time determined on an individual basis - provided the recipient remains eligible and the need for the drug continues to exist.

Information regarding pre-authorization may be obtained by calling TOLL FREE 1-800-372-2986.

16. Lock-In

a. Utilization Review:

Utilization review of recipient participation patterns occasionally demonstrates exceptional and excessive use of Program benefits. Recipients in this category may be placed in lock-in status which limits their physician and pharmacy benefits.

The recipient will remain on the Lock-In Program until the utilization profiles indicate a normal utilization pattern for the recipient's condition. Lock-in limitations only apply to physician and pharmacy services, and do not preclude needed emergency services or referral.

b. Identification of Lock-In Recipients:

Lock-In recipients are identified by a special, pink Medical Assistance Identification Card. Each eligible member of a Lock-In family unit will be issued this special MAID Card monthly. The names of the recipient's Lock-In pharmacy and/or physician provider will be entered on the MAID card each month.

c. Pharmacy Profiling System

Each Lock-In recipient is entitled to Pharmacy services as prescribed by their Lock-In Physician. The number of prescriptions and days' supply are monitored by the selected Lock-In Pharmacist, by use of a profiling system.

Occasionally unique situations arise, which necessitate the dispensing of medication in a manner which deviates from the general guidelines of the Lock-In Program (i.e., more than 4 prescriptions per month). In these situations, the Pharmacist is encouraged to exercise his professional judgement in dispensing the medication(s). If a questionable case should arise, the Pharmacist is encouraged to contact the Lock-In Coordinator for verification of coverage.

The advantages of profiling systems have demonstrated an improved utilization of medication as well as a significant cost savings through a reduction of unnecessary prescriptions.

Program staff will conduct retrospective reviews of utilization patterns and any problems that are identified will be discussed with the Pharmacist.

d. Emergency Situations

If a recipient should request medications from a Pharmacist OTHER THAN THE LOCK-IN PHARMACIST, careful inquiry should be made concerning the reason (emergency - recipient out of town, Lock-In Pharmacist out of medication, etc.) for the request.

If it is determined by the Pharmacist that a real emergency or unique situation exists, the prescription should be dispensed and the Lock-In Coordinator notified by mail or phone, to assure reimbursement. See Page 4.13, Section IV, #8, Lock-In Recipients for further information.

17. Procedure Code

The procedure code to be billed for all prescriptions is 99199.

18. Drug Utilization Review

Drug Utilization Review (DUR) is designed to monitor prescription drug use by Medicaid recipients. The purpose of the DUR is to identify and help resolve problems potentially related to drug therapy. Therapeutically oriented criteria are applied to all medical history profiles and the high risk patients are then confidentially reviewed by a Drug Utilization Review Committee composed of a practicing physician, pharmacist, and registered nurse.

I. Clinical Pharmacist's Services

Clinical pharmacist's services, provided by a licensed pharmacist on the staff of the Primary Care Center, include obtaining and recording recipient medication histories, monitoring drug use, contributing to drug therapy, drug selection, counseling, administering drug program, and surveillance for adverse reactions, and drug interactions.

Individual clinical pharmacist service counseling rendered eligible recipients is a cost-allowed service and shall be documented in the patient's records. Services may be reported on the year-end cost report as a cost of the center's total cost, but can not be billed on the MAP-7.

J. Audiology

Audiology services provided by the Primary Care Center are limited to the services covered through the Hearing Services element of the KMAP. All audiologists must hold a current, unrevoked and unsuspended Kentucky audiologist's license issued by the State Board of Examiners for Speech Pathology and Audiology under KRS Chapter 334. An out-of-state audiologist who holds a Certificate of Clinical Competence issued by the American Speech and Hearing Asscciation, as well as appropriate licenses as required by the state in which he or she practices, may also participate in the KMAP.

All hearing aid dealers must hold a current, unrevoked and unsuspended license issued by the Kentucky Board for Licensing Hearing Aid Dealers under requirements set forth in KRS Chapter 334 or hold a current, unrevoked and unsuspended certificate of endorsement.

If an audiologist meets Program requirements for participation as both an audiologist and as a hearing aid dealer, and is engaged in the practice of both, he may participate in the KMAP as either an audiologist or as a hearing aid dealer, but not both.

All services covered under the Hearing Services element of the Program are currently limited to eligible recipients who have not yet reached their twenty-first birthday (coverage for those turning 21 will continue through the end of their birth month).

1. Audiological Services

   a. Program coverage includes a complete hearing evaluation provided an eligible recipient by an audiologist who meets the requirements for licensure in Kentucky.*

b. Additional coverage extends to a hearing aid evaluation provided by such an audiologist to an eligible recipient, when such is indicated by the results of the hearing evaluation.*

*Equipment utilized in performance of these tests must meet ANSI Standards and Specification. The audiometer should be checked at least once per year to assure proper functioning; proof of calibration and/or repairs should be available. The audiometer should be checked periodically by a simple listening test with the same person doing the testing, that person being familiar with the levels at which his hearing responds at each frequency.

c. When a hearing aid has been fitted as the result of the above evaluations, Program coverage includes up to three follow-up visits over a six-month period to insure that the recipient has become properly adjusted to the new hearing aid. Such follow-up should include counseling of recipient and family as to proper use and care of the aid, plus attention to any psycho-social problems resulting from loss of hearing and the wearing of the aid.

d. Six months after final fitting of the hearing aid, a follow-up visit by the recipient to the audiologist is required.

e. Should loss of or extensive damage to a hearing aid purchased through the Program necessitate replacement of the aid, the Program covers the audiologist's complete re-evaluation of the hearing loss.

(1) When replacement of the hearing aid becomes necessary within one year of the original fitting, the second aid will be fitted upon the recommendation of the audiologist.

(2) When replacement of the hearing aid becomes necessary more than one year after the original fitting, the recipient must be examined by a physician and his hearing loss re-evaluated by an audiologist.

f. Should medical, physical, or other conditions pertinent to the recipient's hearing loss change to such extent that use of a hearing aid other than the one originally fitted is indicated, the Program covers the audiologist's complete re-evaluation of the hearing loss.

NOTE: The audiologist is required to give the appropriate written, signed, and dated statements regarding the replacement aid as described for recommendation and fitting of the original aid. See page 4.71, Hearing Aids, 2b.

g. Exclusions from Benefits - The following services are at the present time excluded from Program benefits:

(1) Routine screening of individuals or groups for identification of hearing problems. Program coverage extends only to those hearing evaluations performed when the recipient has been referred to the audiologist or hearing clinic by a physician or when there has been some indication of hearing loss prior to the evaluation.

(2) Hearing therapy except as covered through six-month adjustment counseling following fitting of a hearing aid.

(3) Instruction in lip reading, except as covered in six-month adjustment counseling following fitting of a hearing aid.

(4) Any item or service for which the individual has no obligation to pay and which no other person has a legal obligation to provide or pay for.

(5) Benefits are limited to those eligible recipients who have not yet reached their twenty-first birthday. Those 21 and over are currently excluded.

2. Hearing Aids

a. The KMAP can make payment to a participating hearing aid dealer for a hearing aid provided to an eligible recipient, when that recipient has been examined by a physician and an audiologist who meets Program standards for participation. Examinations by, and recommendations of, the physician and the audiologist must be rendered within ninety (90) days prior to the fitting. (This 90-day period begins on the date of the physician's examination or the audiologist's evaluation, whichever is earlier.)

b. Reimbursement by the Program for the hearing aid will be authorized only when the physician has examined the recipient and the audiologist has verified the recipient's hearing loss and has recommended that a hearing aid is necessary and will improve the recipient's hearing ability. Also, the hearing aid dealer must have provided the recipient with an aid specifically recommended by the audiologist.

If a hearing aid is needed as a result of the hearing evaluation and the hearing aid evaluation, the audiologist must recommend that an aid be fitted for the recipient who is given the following papers:

(1) The written, signed, and dated Statement of Medical Clearance from the examining physician and

(2) A written, signed, and dated recommendation for a hearing aid to include the make and model of the hearing aid. The recipient should be instructed to then take these to a KMAP participating hearing aid dealer to obtain the recommended hearing aid.

c. General Program coverage extends only to monaural hearing aids.

d. When the recipient suffers from refractive error and the audiologist recommends use of an eyeglass hearing aid, Program payment can be made for the hearing aid and for the eyeglass temples. Other financial arrangements may be made by the hearing aid dealer for payment of any incurred cost of eyeglass fronts or lenses.

e. Program reimbursement for the hearing aid is to be considered payment in full for all components and attachments necessary for initial, successful operation of the instrument*, plus general service to the instrument for a period of one year. General service is to include any cleaning, adjustent, and minor repairs to the instrument, which do not necessitate return of the instrument to the manufacturer. When Program payment is requested for the hearing aid, the dealer agrees to accept this payment as payment in full for the above items and services, even though the amount of Program payment may not equal his usual and customary charge for the hearing aid. Additional remuneration may not be accepted from the recipient or any other source toward these items or services. *Eyeglass Hearing Aid exception - See preceding paragraph.

f. Cords - The Program will reimburse the hearing aid dealer for replacement cords necessary for proper functioning of the hearing aid.

g. Repairs - The Program will reimburse the hearing aid dealer for necessary repairs to the hearing aid, when such repairs entail replacement of vital components of the aid and necessitate return of the aid to the manufacturer. No reimbursement will be made by the Program for repairs normally covered by the manufacturer's guarantee.

h. Replacement of aid

(1) Should a hearing aid purchased through the Program be lost, or damaged to an extent which makes effective repair impossible, the Program can make payment for a replacement hearing aid. In case of extensive damage, written verification must be obtained from the manufacturer attesting to the impossibility of repair of the aid.

(a) If replacement becomes necessary within one year of the original fitting, the second aid will be fitted upon the recommendation of the audiologist.

(b) If replacement becomes necessary after the original fitting, the recipient must be examined by the physician and his hearing loss re-evaluated by an audiologist.

(2) Should medical, physical, or other conditions pertinent to the recipient's hearing loss change to such extent that use of a hearing aid other than the one originally fitted is indicated, the Program can make payment to the audiologist for a complete re-evaluation of the hearing loss. Recommendation for the fitting of a replacement aid must be received from an audiologist, through the same procedures followed in the fitting of the original hearing aid.

(a) Replacement will not be covered upon request by the recipient only.

(b) Replacement for the sole purpose of incorporating recent improvements or innovations in hearing aids will not be covered, unless such replacement will result in appreciable improvement in the recipients hearing ability, as determined by evaluation of the audiologist. In such cases, the audiologist's full written explanation must accompany the hearing aid dealer's billing for the fitting.

i. Exclusion from Benefits - The following items are specifically excluded from Program coverage. Payment for same may be requested from the recipient if applicable.

(1) Binaural hearing aids. Each recipient is limited to one aid per ear per date of service. A replacement aid can be processed at a later date if the replacement aid is for the same ear.

(2) Replacement batteries for the initially purchased hearing aid.

(3) Replacement earmold for the initially purchased hearing aid.

(4) Telephone switches, unless built in by manufacturer as standard part of hearing aid and included in standard charge for hearing aid.

(5) Devices for listening to radio and television.

(6) Other accessories not usually part of a standard hearing aid and unnecessary for basic operation of a hearing aid.

(7) Preparations for cleaning of hearing aids.

(8) Ointments and drops for relief of irritation caused by wearing of hearing aid.

(9) Any item or service for which the recipient has no obligation to pay and which no other person has a legal obligation to provide or pay for.

Procedural Coding

Covered services provided by an eligible audiologist and/or hearing aid dealer on the staff of the primary care center should be entered on the MAP-7, Invoice form.

A. Procedure Codes

The following are codes used in billing the covered services reimbursable to audiologists:

V5000	Audiometric Exam - Hearing Exam Including The Measuring of Hearing Acuity and Tests Relating to Air Conduction, Bone Conduction, Speech Reception, Threshold and Speech Discrimination
V5010	Hearing Aid Evaluation Test
V5020	Conformity Evaluation (Up to 3 Visits Within 6-month Period Allowable)
W0030	Six-Month Follow-Up Visit

B. Procedures codes

The following are codes used in billing the covered services reimbursable to a hearing aid dealer. Billings for hearing aids must include the needed attachments with the submitted MAP-7 in accordance with the following:

1. Initial Aid

   (a) Attach a signed, dated specification for the hearing aid to include name, make and model,

   (b) Attach a signed and dated statement of Medical Clearance from the examining physician, and

   (c) Laboratory Invoice from the manufacturer for the cost of the aid, earmold, and batteries.

2. Replacement Aid (Less than 12 months since previous aid was fitted.)

   (a) (Same a #1a)...and
   (b) Attach the manufacturer's statement of irreparable damage to the previous aid if applicable.
   (c) Attach a signed, dated statement of significant hearing improvement with the use of the new aid from the audiologist, and
   (d) Same as 1,c.

3. Replacement Aid (Over 12 months since previous aid was fitted)

   (a) (Same as #1(a)...and
   (b) (Same as #2(b)...or
   (c) (Same as #2(c)...and
   (d) (Same as #1(c)...and
   (e) (Same as #1(b).

a.

V5030	Hearing Aid, Monaural, Body Worn, Air Conduction
V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction
V5050	Hearing Aid, Monaural, In The Ear
V5060	Hearing Aid, Monaural, Behind The Ear
V5090	Dispensing Fee
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear
W0073	Earmold (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)

	W0074	Battery (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)
b.	W0080	Professional Fee for Replacement of Cord
	W3051	Replacement of Cord
c.	W0090	Professional Fee for Repair of Aid
	W3052	Cost of Aid Repair
d.	W0075	Adaption of the Hearing Aid for use with a Bone Oscillator and Headband (To be billed only with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)

K. Vision

Vision care services are limited to the services covered through the Vision Care Services element of the Medical Assistance Program.

1. Eligibility Requirements

The recipient must be eligible for services when the supplies (eyeglasses) are ordered, since the order date is considered to be the "Date of Service" when billing for professional procedures and laboratory procedures. This date will be the same as found on the laboratory invoice which must be attached to bills. (Approval of a prior authorization does not mean the recipient is eligible at the time of approval or at a later date.)

2. Diagnostic Services

The Program can reimburse optometrists for examinations and limited diagnostic services for all eligible recipients, regardless of age. Please refer to the American Optometric Association (AOA) 1984 Edition Booklet entitled, "Optometric Procedures - Diagnostic and Treatment" Section I, II, and IV. Of the services listed therein, the following are NOT covered:

Section II - INDEPENDENT OPTOMETRIC DIAGNOSTIC PROCEDURES

I. MICROBIOLOGY SERVICES

J. UNLISTED DIAGNOSTIC PROCEDURE

Section IV - SPECIAL SERVICES AND REPORTS

ADMINISTRATIVE SERVICES (Exception 99050 - Services requested after hours in addition to basic service.)

Limitations on Covered Office and Home Visits

New patient office medical services codes 90000, 90010, 90015, 90017 and 90020 are limited to one (1) per patient, per provider per twelve (12) month period.

Established patient medical services codes 90070, 90080, and 90170 are limited to one (1) per patient, per provider, per twelve (12) month period.

New patient home medical services codes 90100, 90110, 90115, and 90117 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92002 and 92004 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92012 and 92014 are limited to one (1) per patient, per provider, per twelve (12) month period.

Procedure codes 92002, 92004, 92012, and 92014 may NOT be used with the following procedure codes: 90000, 90010, 90015, 90017, 90020, 90030, 90040, 90050, 90060, 90070, and 90080.

3. Eye and Ocular Adnexa Services

Coverage of the following services is effective with July 15, 1986, dates of service and thereafter. Compliance with the effective date of this coverage will be enforced through post-payment review.

65205	Removal of foreign body, external eye; conjunctival superficial
65210	Removal of foreign body, conjunctival embedded (includes concretions), subconjunctiva or scleral nonperforating
65220	Removal of foreign body, corneal, without slit lamp
65222	Removal of foreign body, corneal, with slit lamp
67820	Correction of trichiasis, epilation, by forceps only
68800	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral
68820	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral

4. Eyeglasses

a. Conditions of coverage

The KMAP can cover eyeglasses when the following conditions are met. The KMAP requires that the services listed in this subsection 4. Eyeglasses be prior authorized before payment is made. Prior authorization Form MAP-8 and instructions for completion can be found in the Appendix.

(1) Age

The Program can cover laboratory costs of frames, lenses, and appropriate dispensing fee for services rendered to all eligible recipients up to the age of 21 (coverage for those turning 21 will continue through the end of their birth month).

(2) Diagnosis

Eligible recipients must be in one of the following four categories:

(a) Amblyopia
(b) Post surgical eye care
(c) Low or subnormal vision
(d) Other diagnostically indicated need for eyeglasses

(3) Minimum Prescription

Visual conditions requiring prescriptions for correction shall contain power in the stronger lens no weaker than the following:

+0.50 or -0.50 sphere +0.50 or -0.50 cylinder
0.50 diopter of vertical prism
A total of 2 diopters of lateral prism

(4) Frame and Lenses Requirement

(a) Frame

1) All frames must be of domestic distribution, first quality and free of defects. The material must be normally resistant to damage or breakage, and must be finished with a high polish.

2) To enable replacement of lenses and frame parts, all frames must have imprinted on them the following information: Eye size, bridge size, temple length, and the manufacturers' name or trademark.

3) The provider must allow the patient to try on and select from an adequate selection of appropriate, approved frame styles. The minimum selection is to be three each of girls' and boys' frame styles, and three sizes of each style. The recipient may use his own frame if he or she chooses.

(b) Lenses

1) Only first quality lens may be used. They must be available in a complete range of corrected curves. They must be free of defects and packaged in the manufacturers original envelope or box, and must meet the inspection, tolerance, and testing procedures of the American Standard Prescription Requirements.

2) Unless contraindicated, case hardened lenses should be prescribed for all recipients.

3) In those cases where a change in prescription has been made within twelve consecutive months, only the lenses are to be changed and must meet the minimum change in prescription stated under limitations in coverage. The frame cannot be replaced if it is intact and appropriate.

NOTE: Supplies and materials other than eyeglasses and visual aids used in a diagnostic service such as eye drops, cotton swabs, etc. are considered to be part of the service therefore they are included in the payment for the service rendered and additional charges may not be made to the Program or the recipient for these items.

b. Limitations in coverage

(1) Recipients are limited to 2 pairs of glasses per 12 months in accordance with the following:

-The recipient may have two complete pairs of eyeglasses within a 12 month period beginning with the date of his/her first or initial pair. (Recipients are limited to one initial pair within 12 months.) The second or replacement pair may be a completely new pair of glasses.

OR

-The recipient may receive 2 replacement pairs of glasses within 12 months beginning with the date he receives his first replacement pair;

OR

-The recipient may receive any combination of parts for his/her glasses; e.g., 2 fronts, 1 temple, 4 lenses; so long as the total parts combined make up NO more than two pairs of glasses;

OR

-The recipient may receive one initial pair or one replacement pair and any combination of parts so long as the total parts combined make up no more than one additional pair of glasses.

(2) Changes in prescription must meet a minimum of:

±0.50 sphere
±0.50 cylinder
1.00 cylinder or less--10° change in axis
1.25 cylinder or greater--5° change in axis

(3) Telephone contacts are excluded from payment.

(4) Contact lenses are excluded from payment. However fitting of contact lenses is payable but must meet one of the following criteria:

(a) CORRECTED acuity in the best eye is 20/50 and can be improved with use of contact lenses or;

(b) Visual prescription of ±8.00 diopter or greater, or;

(c) 4.00 diopter anisometropia (difference in power between eyes) or;

(d) MEDICALLY INDICATED or MEDICALLY NECESSARY is written or typed on claim form or attach the same in the form of a written or typed note or a formal attachment such as the invoice or patient chart to the claim form. The patient's record must document that this method of correction was medically necessary or medically indicated.

(5) Safety glasses are excluded from payment except in those cases where the recipient is blind in one eye or has only one eye. In these cases, this must be entered on both the pre-authorization request and the billing form.

(6) Tint is payable only if the prescription specifically states the diagnosis of photophobia. This must be entered on both the pre-authorization request and the billing form.

(7) Program reimbursement for eyeglasses must be considered payment in full. The cost of both laboratory materials and dispensing fees must be billed to either the Program or the recipient. Should any portion of the amount be billed to or paid by the recipient, no responsibility for reimbursement shall attach to the Department and no bill for the service shall be paid by the Department.

5. Dispensing of Eyeglasses

This includes single or bifocal vision prescription, services to frames, and delivery of completed prescription.

a. SINGLE VISION PRESCRIPTIONS. The lens selection and design should meet the recipient's physical, occupational, and/or recreational requirements. The finished prescription must be verified by the prescriber to ascertain that it meets the lens power and lens specifications ordered. It is the responsibility of the prescriber to ascertain that only first-quality materials approved by the KMAP are being provided the recipients, and that the fabrication conforms to the standards. The prescriber shall be responsible at no further cost to the KMAP or the recipient for the replacement of inaccurately filled prescriptions, non-authorized materials, defective materials, or improperly fitting lenses.

b. BIFOCAL PRESCRIPTIONS. Same requirements as #1 unless contraindicated Kryptok bifocals are prescribed.

c. SERVICES TO FRAMES. This includes frame selection and measuring to meet the recipient's facial fitting, occupational and/or recreational requirements. The provider must allow the patient to try on and select from an adequate selection of appropriate, approved frame styles. The minimum selection is to be three each of girls' and boys' frame styles, and three sizes of each style. The recipient may use his own frame if he or she so chooses. The finished prescription should be verified by the provider to ascertain that it meets the frame specifications ordered. It is the responsibility of the provider to ascertain that only first-quality materials approved by the KMAP are being provided the recipients. The provider shall be responsible at no further cost to the KMAP or the recipient for inaccurately filled prescriptions, non-authorized materials, defective materials, or improperly fitting frames.

d. DELIVERING COMPLETED PRESCRIPTION. This includes at no further cost to the KMAP or the recipient instructing the recipient in the use of the prescription, adjustment of the prescription, and subsequent minor adjustments for a period of one year.

6. Professional Services for Dispensing and Repairing Eyeglasses

The procedure codes for dispensing and repairing eyeglasses as contained in the American Optometric Association (AOA) 1984 Edition Booklet entitled, "Optometric Procedures - Diagnostic and Treatment," Section III are as follows:

92340 -
92341 -
92352 -
92353 - Professional fee for the dispensing of the INITIAL PAIR of eyeglasses. The initial pair always includes BOTH the frame and lenses.

92370 - Professional fee for the dispensing of a REPLACEMENT PAIR or part of the eyeglasses. When a lens prescription change is necessary while the frame continues to be functional, even longer than 12 months, the replacement code should be used.

W0091 - Hinge Repair - This is inclusive of both the professional fee and supply cost. Do NOT bill with procedure code for professional services.

Of the services listed in the (AOA) 1984 Booklet, the following are NOT covered:

Section III - OPTOMETRIC TREATMENT SERVICES

A. OPHTHALMIC LENS TREATMENT SERVICES

92342 Treatment with spectacles, except for aphakia; multifocal, other than bifocal

92358 Prosthesis service for aphakia, temporary

B. CONTACT LENS TREATMENT SERVICES

92070 Prescription and management of contact lens for treatment of disease, including supply of lens.

92325 Modification of contact lens

92326 Replacement of contact lens

C. LOW VISION TREATMENT SERVICES

D. VISION THERAPY SERVICES

The (ICD-9-CM) and (COPT) procedure coding structures are not acceptable.

E. PROSTHETIC EYE SERVICES

F. ANISEIKONIC TREATMENT SERVICES

G. OTHER PROCEDURES

7. Laboratory procedure codes for eyeglasses and parts are as follows:

V2020	Frames, Purchases
V2100	Sphere, Single Vision, Plano to Plus or Minus, 4.00, Per Lens
V2101	Sphere, Single Vision, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2102	Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2103	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2104	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2105	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2106	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens
V2107	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00 Sphere, .12 to 2.00D Cylinder, Per Lens
V2108	Spherocylinder, Single Vision, Plus or Minus 4.25D to Plus or Minus 7.00 Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2109	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2110	Spherocylinder, Single Vision, Plus or Minus 4.25 to 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2111	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, .25 to 2.25D Cylinder, Per Lens
V2112	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25D to 4.00D Cylinder, Per Lens
V2113	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 2.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2114	Spherocylinder, Single Vision, Sphere Over Plus or Minus 12.00D, Per Lens
V2115	Lenticular, (Myodisc), Per Lens, Single Vision

V2116	Lenticular Lens, Nonaspheric, Per Lens, Single Vision
V2117	Lenticular, Aspheric, Per Lens, Single Vision
V2118	Aniseikonic Lens, Single Vision
V2199	Not Otherwise Classified, Single Vision Lens
	Bifocal, Glass or Plastic (Up to and Including 28mm Seg Width, Add Power Up to And Including 3.25D)
V2200	Sphere, Bifocal, Plano to Plus or Minus, 4.00D, Per Lens
V2201	Sphere, Bifocal, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2202	Sphere, Bifocal, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2203	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2204	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2205	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2206	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens
V2207	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2208	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2209	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2210	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2211	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 25 to 2.25D Cylinder, Per Lens
V2212	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25 to 4.00D Cylinder, Per Lens
V2213	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2214	Spherocylinder, Bifocal, Sphere Over Plus or Minus 12.00D, Per Lens
V2215	Lenticular, (Myodisc), Per Lens, Bifocal
V2216	Lenticular, Nonaspheric, Per Lens, Bifocal
V2217	Lenticular, Aspheric Lens, Bifocal

V2218	Aniseikonic, Per Lens, Bifocal
V2219	Bifocal Seg Width Over 28mm
V2220	Bifocal Add Over 3.25D
V2299	Specialty Bifocal
V2410	Variable Sphericity Lens, Single Vision, Full Field, Glass or Plastic, Per Lens
V2430	Variable Sphericity Lens, Bifocal, Full Field, Glass or Plastic, Per Lens
V2499	Not Otherwise Classified, Variable Sphericity Lens
W0094	Front Only
W0093	One Temple Only
W0092	Two Temples Only

8. Miscellaneous Services

W0091 Hinge Repair - This is inclusive of both the professional fee and supply cost. Do NOT bill with procedure code for professional services.

All of the above procedure codes represent one unit of service and must be entered as such on the billing form.

SECTION IV - SERVICES COVERED

L. Home Health Services

The home health component of a primary care center must meet the standards for, and include, the same provision of services as the home health element of the KMAP. The component must be licensed as a home health agency, and be certified for participation under Medicare (Title XVIII).

If a primary care center meets the above requirements and wishes to bill Title XIX for home health services, contact the Division of Policy and Provider Services at 502/564-6890 for further information.